Coverage and Access to Care for Older Californians

Debra Sheets, RN, Ph.D.
Assistant Professor of Health Sciences
California State University, Northridge
July 2001

Overview

The population of California is aging rapidly in what has been described as the "graying of the Golden State" (Tafoya and Johnson, 2000). Both the total numbers and relative proportions of older Californians are increasing and this trend will accelerate after 2010 when the first of the baby boomers (those born between 1946 and 1964) reach age 65. An estimated 3.6 million Californians (11 percent of the total state population) are age 65 or older. By 2030, the older population will more than double to 8.9 million (17 percent), and one in three Californians will be over the age of 50. The fastest growing age group is the "very old", those age 85 and over, who will increase nearly fourfold in numbers from 450,000 in 2000 to 1.7 million by 2040. Among this "very old" age group, there are twice as many women as men (Federal Interagency Forum on Aging Related Statistics, 2000).

Compared to younger Californians, the older population, ages 65 and over, has the advantage of the Medicare program which provides universal and publicly financed health insurance that assures access to hospital (Part A) and supplementary (Part B) health care. Yet, in other ways the elderly remain disadvantaged in their insurance coverage because they lack comprehensive health benefits and lack access to affordable coverage for long-term care (Feder, 1990, Feder and Lambrew, 1996). Taken together, these gaps in health care coverage leave seniors unprotected against high out-of-pocket costs and at-risk for the catastrophic costs of long-term care (Feder, 1999). This background paper examines these gaps in insurance coverage for seniors and identifies several options for controlling costs and expanding coverage to ensure the adequacy, affordability, and accessibility of health care for older Californians.

The Need

An important issue affecting the access and affordability of health care for seniors is the comprehensiveness of insurance benefits. Most private health insurance plans provide a comprehensive range of benefits that typically include pharmaceutical benefits and stop-loss (catastrophic) coverage. Medicare benefits are lagging behind expansion in the private market for insurance. This leaves Medicare fee-for-service beneficiaries with increasing financial liabilities for the health services they need which are not covered. These widening gaps in Medicare coverage reflect reluctance to expand program benefits in the context of rising health care costs and a rapidly growing older population.

The lack of comprehensive health benefits in traditional Medicare leaves seniors, most of whom have low or modest incomes, vulnerable to rising out-of-pocket costs. The most common health care needs of older adults—prescription drugs, eyeglasses, hearing aids or dental care—are not covered. The resulting gaps in coverage along with increasing cost-sharing responsibilities (e.g.

premiums, deductibles and co-payments) create a significant financial burden for seniors who are poor, disabled or have multiple chronic conditions (Moon, Breenan and Segal, 1998).

In the absence of comprehensive benefits, 90 percent of Medicare beneficiaries try to fill these gaps in coverage with additional health insurance (Maxwell, Moon and Storeygard, 2001). The most common sources include:

- Employer-sponsored supplemental insurance (retiree benefits): 30 percent
- Medigap (individual supplemental) insurance: 23 percent
- Medicare managed care (Medicare+Choice): 15 percent
- Medicaid coverage: 13 percent, and
- Current employers: 9.3 percent

Another issue affecting seniors is the lack of affordable long-term care insurance to protect against the small but potentially catastrophic risks of needing long-term care. Around 1900, life expectancy was 47 years and only 4 percent of the population survived to the age of 65. Acute illnesses (e.g. infectious disease) were the leading causes of death. Today, individuals can expect to live, on average, 77 years and the leading causes of death are chronic conditions (e.g., diabetes, heart disease) (Partnership for Solutions, 2001). Multiple chronic conditions are positively correlated with increased risk for disability and the need for long-term care.

Long-term care (LTC) refers to the social, health and personal care needed by persons with chronic disabling conditions. The need for LTC is usually determined by limitations in *activities of daily living* (ADLs) (e.g., personal care activities such as eating, bathing dressing) or *instrumental activities of daily living* (IADLs) (e.g., shopping, managing medications, preparing meals).

LTC is provided in a variety of settings such as the home, adult day care, assisted living or nursing home. Families provide the majority of unpaid LTC (92%) in their homes. Only three percent of older adults are long-term residents in nursing homes. The major payer for nursing home care is Medicaid (Medi-Cal) while Medicare has become the primary payer for home care (Merlis, 1999). The vast majority of LTC expenditures (80%) are allocated towards institutional care, but the availability of home and community-based services is increasing.

Major Issues

In considering issues impacting senior access to care three predominate:

1 <u>High Out-of-Pocket Costs</u>

Although most seniors had additional insurance to supplement their Medicare benefits, the average amount spent yearly on health care costs ($3142) consumed 22 percent of personal income (Maxwell, Moon and Storeygard, 2001). By 2025, the proportion of personal income spent on health care is projected to rise to 30 percent (Maxwell, Moon and Segal, 2001). This trend reflects efforts since the 1980s to shift more of the Medicare program costs onto the elderly. Most recently the Balanced Budget Act (BBA) of 1997 made changes in the Medicare Program which permanently set the monthly premium for Part B (Supplementary Insurance) at 25 percent of the total cost of services covered under Part B. Currently, the

monthly premium is $45.50 but it will rise to $106 by 2007 (Moon, 1999). Seniors with an income level at 125 percent of poverty will be paying 9 percent of their income for health care.

Older adults who are poor, report worse health, and have disabilities are most likely to report problems paying for their medical care (Neuman et al., 1999). About one in seven older adults report that paying medical bills in past year was "very difficult" or that they spent all their savings to pay for medical care. (Schoen et al., 1998)

2 Rising Costs of Pharmaceuticals

Prescription drugs are used by 77 percent of seniors on a regular basis (Moon, 1999). Yet one-half (52 percent) of older Americans have no coverage for prescription drugs and one in six (16 percent) report spending more than $100 monthly out-of-pocket for prescription drugs (Schoen et al., 2000). About 7 percent of the elderly report not filling a prescription drug for financial reasons.

3 Long-Term Care

Individuals must pay out-of-pocket for LTC until they become sufficiently impoverished to qualify for Medi-Cal. The average yearly cost of a nursing home is $48,000 and most seniors "spend down" their assets within 2 years (Wiener and Stevenson, 1998). About 22 percent of older Americans are "very concerned that they will not have enough money or insurance to pay for the LTC services they will need" (Schoen et al., 2000)

One in three adults age 70 and over living in the community receives LTC help because they have difficulty with or are unable to perform daily activities such as shopping, dressing, bathing or managing money (Kramarow, Lentzner, Rooks, Weeks and Saydah, 1999). As the population ages, the need for caregivers will increase, but family caregivers are increasingly unavailable because of factors that include families having fewer children, increasing geographic distances between family members, and higher proportions of women working (Scharlach, 2001).

The Scope

Cost and affordability are particularly vexing issues that disproportionately affect older persons on fixed incomes. The need is challenging for pharmaceuticals, supplemental insurance coverage, and long-term care where Medicare coverage is time limited.

Pharmaceutical Cost

The rapidly rising costs of prescription drugs are a growing source of concern for most seniors. Overall spending for drugs has risen at 11 percent per year making it the fastest growing major cost for both private and public health care programs (Alliance for Health Reform, 2001). In 1996, California seniors paid 30 percent of their total drug costs out-of-pocket (Families USA, 2000).

Supplemental Coverage Cost

Available and affordable supplemental coverage that adequately fills the gaps in Medicare benefits is becoming rare:

Employer-sponsored supplemental insurance

A steady decline in employee supplement insurance (ESI) as a retiree benefit is occurring. Since 1988 the proportion of large employers offering ESI has dropped from 66 percent to 37 percent (Maxwell, Moon and Storeygard, 2001).

Managed Care

In 2000, 40 percent of California seniors were enrolled in Medicare managed care plans (Medicare+Choice). Overall the realities of Medicare+Choice have not matched the hopes. A key incentive to seniors was the promise of better benefits and reduced out-of-pocket costs. Financial pressures have led many managed care plans to reduce their benefits, to reduce the areas they serve, or to withdraw from the Medicare+Choice program (e.g. Cigna) (Echeverria, 2000). In 2000, 37% of the managed care plans reduced their prescription drug coverage and increased cost-sharing for other benefits which has reduced the appeal of the plans (Cassidy and Gold, 2000). Overall, managed care has not protected seniors from high out-of-pocket costs (Gold and Achman, 2001). Beneficiaries with poorer health spend 18 percent of their income on out-of-pocket medical costs (Kasten, Moon and Segal, 2000)

Medigap

The rising cost of premiums for Medigap (supplemental) plans are making them unaffordable for older adults with average incomes (Moon, 1999). Moreover, most plans are cutting back on benefits such as prescription coverage which attract patients with poorer health.

Medicaid

About one in five Medicare beneficiaries is eligible for full or partial Medicaid benefits which reduces their financial liability for health care providing they meet certain limitations on income and assets (Komisar, Feder and Gilden, 2000):

> *Full eligibility.* About 15 percent (759,595) of low-income Californians are "dual eligibles"—they qualify for full benefits from both the Medicare and Medicaid programs. These are individuals who receive Supplemental Security Income (SSI) or who are medically needy because their health care costs exceed their net income are eligible.
>
> *Partial eligibility.* Partial Medicaid benefits are provided to poor Medicare seniors through several programs. Since 1989, the Qualified Medicare Beneficiary (QMB) has required states to pay Medicare's Part B premium and cost-sharing for seniors with incomes below the poverty level. Similarly, the Specified Low-Income Beneficiary (SLMB) Program, created in 1995, pays Part B premium for Medicare beneficiaries whose income falls between 100-120 percent of the poverty level (Moon, Brennan and Segal, 1998). Low participation in the QMB (78 percent of those eligible) or SLMB (16 percent) has limited the impact of this approach to reducing

cost-sharing. Some states are reluctant to do outreach efforts to increase participation since that would increase their Medicaid expenditures.

Long-Term Care Costs

In the state of California, long-term care is provided through more than 74 public programs and services placed in six state agencies (Harrington et al., 2000). The system remains fragmented and largely uncoordinated, which poses significant barriers to access for those who need help the most (Smoley, 1999). Major funding sources include:

Medicare. This program pays for 25 percent of the costs of LTC in California (Harrington et. al, 2000). It provides limited skilled nursing facility (SNF) and home health care benefits which are used disproportionately by persons who need long-term care. Home health care users tend to be older, in poorer health, and have lower incomes. Medicare spending for home health grew from $3.9 billion in 1990 to $18.3 billion in 1996 (Nawrocki and Gregory, 2000). In 1997, the problem of rapidly rising home health costs led to a modification of the benefit in the Balanced Budget Act (BBA) which has since curbed the growth.

Medi-Cal (Medicaid). In 1998, Medi-Cal spent $13.5 billion on LTC in California (Streett, 2001). This program pays for 44 percent of total LTC expenditures; nearly 80 percent was spent on institutional care (Wiener and Stevenson, 1998). Unfortunately, Medicaid does not prevent the financial catastrophe associated with long-term care; seniors must become impoverished before they become eligible for services.

Out-of-Pocket. Nearly a quarter (28%) of long-term care costs for nursing homes or home care are paid directly by individuals (Davis and Raetzman, 1999).

Long-Term Care Insurance. Only about 4 percent of seniors have purchased LTC policies, and private long-term care insurance accounts for only 2.5 percent of long-term care expenditures (Wiener, 1996, Coronel, 2000). Long-term care insurance is most affordable when it is purchased in middle age. If purchased at age 65 the average monthly premium for an individual policy was nearly $200 and this rose to $585 per month if purchased at age seventy-nine (Wiener, Tilly and Goldenson, 2000).

Implications for Policy Makers

The counties and various states throughout the nation have demonstrated a variety of program methods that hold promise for controlling costs while providing needed services. The following are illustrative:

Reducing the Costs of Prescription Drugs for Seniors. State-funded pharmacy assistance programs have been established in 14 states to provide low-income seniors and persons with disabilities with financial assistance to purchase prescription drugs. The first state pharmacy assistance programs were established in 1975 when Maine and New Jersey provided prescription drug coverage to Medicare beneficiaries (GAO, 2000). California established a Drug Discount Program in 1999 but the program does not provide drug

coverage—it simply guarantees Medicare seniors the same price that the State of California pays a pharmacy when it buys the medication for a Medi-Cal patient. The program provides California seniors with an average savings of 10-40 percent, but it does not provide senior with a modest income who has disproportionately high prescription costs with any direct financial assistance.

Reducing the Costs of Institutional Long-Term Care. The evidence to date suggests that the costs of long-term care can be reduced by either integrating long-term care services with the acute services provided by managed care organizations or by replacing nursing home services with home- and community-based care. California has two demonstration programs which integrate long-term care with acute care: Senior Care Action Network (SCAN) and the Program of All-Inclusive Care for the Elderly (PACE).

Senior Care Action Network (SCAN) is a social health maintenance organization (SHMO), begun in Long Beach as one of four federal demonstration projects established in 1984. SCAN provides acute care and limited long-term care services to 37,808 Medicare seniors who live in Los Angeles, Orange, Riverside or San Bernadino Counties. (Lewis, 2000).

PACE was piloted in San Francisco more than a decade ago and is a managed care system that provides capitated care to frail elderly or disabled persons who are nursing home eligible. At present, there are four PACE sites in California: Los Angeles, Oakland, Sacramento, and San Francisco. PACE serves 1,035 seniors at a cost of $24.6 million (California Dept. of Health Services, 2001a).

HCFA's Home and Community-Based Service (HCBS) Waivers program allows states to used Medicaid funds to replace nursing home services with home-and community-based care. The Multipurpose Senior Services Program (MSSP) is the only Medi-Cal HCBS waiver program in California which targets frail, older persons who would otherwise live in a nursing home. The $20.7 million program serves 7,890 seniors and provides case management and a range of home and community-based services.

Expanding Insurance for Long-Term Care. The California Partnership for Long-Term Care is a public-private partnership that makes high-quality, affordable, private LTC insurance available to consumers. The goal of the Partnership is to lower demand on Medi-Cal by preventing or delaying the need to enroll in the Medi-Cal program. Individuals who buy LTC insurance policies can protect some of their assets and still become eligible for Medi-Cal LTC services once their private LTC policy is exhausted. So far, the partnership is failing the market test but California remains committed to expanding private LTC coverage by making the insurance more affordable (Wiener and Stevenson, 1998). In California, only 8552 insurance policies have been purchased which is fewer than expected and insufficient to make a difference (California Dept. of Health Services, 2001b).

In considering the health care access needs of older Californians, it seems clear that the aging of the population will require innovative strategies to control health care costs, improve quality and

assure continued access to needed services. The need to improve the balance between nursing home and home- and community-based care is particularly important to address as the "graying of the Golden State" continues with the projected growth of the "very old". At present, the majority of Medicaid spending on long-term care is spent on institutional care. Policymakers have been concerned that expanding home care would expand the numbers of people needing care (and the costs of LTC) rather than substituting for nursing home care. A few states—Oregon, Washington and Wisconsin—have limited their use of nursing home care but have also found they had to limit the availability of home care.

Nursing homes remain extraordinarily expensive and the quality of care they provided has long been a source of ongoing concern (Wunderlich and Kohler, 2001). A recent article in Time magazine highlighted the poor quality of care in California nursing homes which may have resulted in a number of deaths ("Fatal Neglect", 1997). The preference of most seniors is to "age in place" in their homes and communities. The need for affordable LTC insurance that assures access to home- and community-based care is a critical gap in health care benefits that our state must confront to prepare for the coming age boom.

Endnotes

Alliance for Health Reform, "Prescription Drugs, A Primer for Policymakers," http://www.althealth.org

California Department of Health Services (CDHS), On Lok and PACE Replication Program, Sacramento, CA. www.dhs.cahwnet.gov, 2001a.

California Department of Health Services (CDHS), California Partnership for Long-Term Care, Sacramento, CA. www.dhs.cahwnet.gov, 2001b.

Amanda Cassidy and Marsha Gold, "Medicare+Choice in 20000: Will Enrollees Spend More and Receive Less?" Pub. No. 394, (New York: The Commonwealth Fund, August 2000).

Susan Coronel, Long-Term Care Insurance in 1997-98, Health Insurance Association of America, Monograph, 2000.

*Davis, Karen and Susan Raetzman. "Meeting Future Health and Long-Term Care Needs of an Aging Population," (New York: The Commonwealth Fund, December 1999).

Escheverria, Cecilia, "ABCs of Medicare+Choice in California," (Oakland, CA: California HealthCare Foundation, 2000).

Families USA. "Cost Overdose: Growth in Drug Spending for the Elderly 1992-2010." July 2000.

"Fatal Neglect," Time, 27, October 1997, 34-38.

Judith Feder and Jeanne Lambrew, "Why Medicare Matters to People Who Need Long-Term Care," *Health Care Financing Review*, 18,2, Winter 1996, 99-112.

Judith Feder, "Improving Public Financing for Long-Term Care: The Political Challenge," Journal of Aging & Social Policy, 10,3, 1999, 1-6.

Judith Feder, "Health Care of the Disadvantaged: The Elderly," *Journal of Health Politics, Policy and Law*, 15,2, Summer, 1990, 259-269.

Federal Interagency Forum on Aging-Related Statistics. Older Americans 2000: Key Indicators of Well-Being, (Hyattsville, MD: Federal Interagency Forum on Aging-Related Statistics, 2000)

*Marsha Gold and Lori Achman, "Trends in Premiums, Cost-Sharing, and Benefits in Medicare+Choice Health Plans, 1999-2001," (New York: The Commonwealth Fund, April 2001).

*Charlene Harrington, M. Christine Tonner, Valerie Wellin, Martin Kitchener, Brian Kaskie, P. Mark Halladay, Cassandra Crawford, Christopher Ganchoff, and Robert Newcomer, "The Role of Medi-Cal in California's Long-Term Care System," (San Francisco: Medi-Cal Policy Institute, December 2000).

Jessica Kasten, Marilyn Moon and Misha Segal, "What do Medicare HMO Enrollees Spend Out-Of-Pocket?" (New York: The Commonwealth Fund, August 2000).

Harriet Komisar, Judith Feder and Daniel Gilden, "The Roles of Medicare and Medicaid in Financing Health and Long-Term Care for Low-Income Seniors: A Chart Book on Medicare-Medicaid Enrollees in Four States," Pub. No. 375, (New York: The Commonwealth Fund, September, 2000).

Kramarow, Ellen, Harold Lentzner, Ronica Rooks, Julie Weeks and Sharon Saydah. "Health and Aging Chart Book, Health, United States, 1999," (Hyattsville, Maryland: National Center for Health Statistics, 1999).

Valerie Lewis, "Medicaid Waivers: California's Use of a Federal Option," (Oakland, CA: Medi-Cal Policy Institute, March 2000).

Stephanie Maxwell, Marilyn Moon and Matthew Storeygard, "Reforming Medicare's Benefit Package: Impact on Beneficiary Expenditures," (New York: The Commonwealth Fund, May 2001).

Stephanie Maxwell, Marilyn Moon and Misha Segal, "Growth in Medicare and Out-of-Pocket Spending: Impact on Vulnerable Beneficiaries," (New York: The Commonwealth Fund, January 2001

*Mark Merlis, "Financing Long-Term Care in the Twenty-First Century: The Public and Private Roles," (Washington, DC: Georgetown University Institute for Health Care Policy and Research, September 1999).

Marilyn Moon, "Will the Care Be There? Vulnerable Beneficiaries and Medicare Reform," *Health Affairs*, Jan-Feb 1999, 107-117.

Marilyn Moon, Nial Brennan, and Misha Segal, "Improving Coverage for Low-Income Medicare Beneficiaries" (policy brief), (New York: The Commonwealth Fund, December, 1998).

Heather Nawrocki and Steven Gregory, "Across the States 2000, Profiles of Long-Term Care Systems," 4th edition, (Washington, DC: Independent Living/Long-Term Care Public Policy Institute, AARP, 2000).

Patricia Neuman, Diane Rowland, Michelle Kithman, Drew Altman, Cathy Schoen, Karen Davis, Elaine Puleo, "Understanding the Diverse Needs of the Medicare Population: Implications for Medicare Reform," *Journal of Aging & Social Policy*, 10,4, 1999, 25-50.

Partnership for Solutions, Johns Hopkins University and The Robert Wood Johnson Foundation http://www.partnershipforsolutions.org/problem/index.htm

Andrew Scharlach, "Family Caregiving for Older Californians," (University of California: California Policy Research Center (CPRC) Brief, 11, May 2001).

Cathy Schoen, Erin Strumpf, Karen Davis, Robin Osborn, Karen Donelan, and Robert Blendon, "The Elderly's Experiences With Health Care In Five Nations," (New York: The Commonwealth Fund, May 2000).

*Cathy Schoen, Patricia Neuman, Michelle Kitchman, Karen Davis, and Diane Rowland, "Medicare Beneficiaries: A Population at Risk, Findings from the Kaiser/Commonwealth 1997 Survey of Medicare Beneficiaries" (Menlo Park, CA: The Kaiser Family Foundation and Health Research and Educational Trust, December, 1998).

* Lucy Streett, Understanding Medi-Cal: Long-Term Care, (Oakland, CA: Medi-Cal Policy Institute, April 2001).

Sonya Tafoya and Hans Johnson, "Graying in the Golden State: Demographic and Economic Trends of Older Californians," California Counts Population Trends and Profiles, 2,2, (San Francisco: Public Policy Institute of California, November 2000).

Andrew Scharlach, Fernando Torres-Gil, and Brian Kaskie, "Strategic Planning Framework for an Aging Population," (University of California, California Policy Research Center (CPRC) Brief, 1, May 2001).

Sandra Smoley, "Report on Long Long-Term Care Programs and Options for Integration," (Sacramento, CA: California Health and Human Services Agency, January 1999).

United States Government Accounting Office (GAO), State Pharmacy Programs, Assistance Designed to Target Coverage and Stretch Budgets, GAO/HEHS-00-162, September 2000

* Joshua Wiener and David Stevenson, "Long-Term Care for the Elderly: Profiles of Thirteen States," Assessing the New Federalism, *Urban Institute*, Occasional Paper Number 12, August 1998.

*Joshua Wiener, Jane Tilly and Susan Goldenson, "Federal and State Initiatives to Jump Start the Market for Private Long-Term Care Insurance," *The Elder Law Journal*, 8, June 2000, 57-99.

*Joshua Wiener, and David Stevenson, "State Policy on Long-Term Care for the Elderly," *Health Affairs*, May-June 1998, 81-100.

*Joshua Wiener, "Can Medicaid Long-Term Care Expenditures for the Elderly Be Reduced?" (New York: The Commonwealth Fund, June 1996).

Gooloo Wunderlich and Peter O. Kohler, (Eds.), Improving the Quality of Long-Term Care, Committee on Improving Quality in Long-Term Care, Division of Health Care Services, Institute of Medicine, 2001

*Recommended reading

This paper was prepared for the California Health and Human Services Agency's Health Care Options Project under the direction of the California Research Bureau. Funding for this effort was provided by a grant from the Health Resources and Services Agency of the U.S. Department of Health and Human Services.